Right at the end of this huge effort, however, I think we 'cracked it' for some new wisdom about why it is so hard for staff and consumers in psychiatric services to come together and jointly discuss and plan. This went way beyond the initial claims of 'no time, too-busy' to the question of priorities and low morale, and to consider deeper issues of staff's fears about consumer input; fears of loss of control and of appearing unprofessional by seeming to 'not know' in order to ask consumers questions; fears of inpatients' behaviour and lack of organisational support to recover from the emotions triggered in staff by this; and to understand the way in which existing systems find it difficult to present new and better ways of doing things. Having learned painstakingly how to successfully involve consumers—and keep consumers involved-and also how to engage a small number of staff and consumers in deep dialogue about matters troubling them, we came to understand that one important missing element was resources to support staff to deal with their own stress, exhaustion, low morale, fear, guilt, and so on. Ironically at the RMH Intensive Care Unit (ICU) there is a full time psychologist. On acute psychiatric units—which at present are truly ICUs as well—there are no organisational supports to staff at all (even if staff could avoid seeing the need for this as a sign of weakness).

It emerged from this study that the success of any managerial attempt to secure consumer evaluation rests in the first place on there being consumers ready, willing and able to supply evaluative comment. Secondly for that consumer evaluation to contribute in terms of change and improvement to existing service delivery, there also need to be staff - including management - who are ready, willing and able to receive that comment and enter into dialogue with consumers about it.

For each group to 'come to the table', much needs to happen in terms of resourcing each group to feel confident, safe and good enough about themselves - for consumers to speak, and for staff to be able to hear, before deep dialogue can take place. We were able to achieve the first set of conditions - identifying and trialing conditions such as consumer-only support groups, and payment to signify the value of consumers' input. But it was beyond our resources and our brief to provide the kind of supportive resources to enable stressed, exhausted and defensive staff to sit through the first waves of hearing consumers' stories of hurtful practice. As we noted in our penultimate project bulletin - a comment applying to both staff and consumers:

> 'Why enter into shark-infested water if you are bleeding.'
> Why indeed. What more could be done?

Conditions for shifting the power relations towards health promotion

What if the Victorian Health Promotion Foundation Research Committee hadn't had a sophisticated understanding of the methodology proposed, or had been unprepared to place the funds in the hands of a consumer organisation? What if our extraordinary research team partnership had been nipped in the bud—or never come together in the first place? What if the Research and Ethics Committees had not recognised and had faith in what our project was about—even in advance of concrete advice being possible on exactly how the study would be conducted? What if we had not been able to start with, retain and revive a strong consumer perspective and had not continued to strive to apply the same ethical and human expectations to our interactions with staff which we were wanting staff to adopt in their interactions with inpatients and ex-consumers? What if we had not been able to physically occupy the environment in an intensive way, over a very long period of three and more years? What if we had not been supplied with a geographic 'free space' in which to stage dialogue between staff and consumers, and to slowly build relationships with staff—carefully observing and inquiring into the invisible barriers we were encountering? What if a small number of staff had not had the courage to 'stick it out' with us, to keep talking with us, to trust us enough to say things to us they would never otherwise have shared with anyone except perhaps with colleagues who were closely trusted friends, and to keep coming back and for consumers to keep coming back—even when it was painful and we each made mistakes? What if we had not found our way to 'dialectical dialogue' rather than only adversarialism or consensus? What if we had not had a position of relative freedom from authority relationships, and the opportunity this gave us to speak and proceed as we wished in an environment where so few feel free to speak or act as they would want to - particularly keeping faith with consumers? What if we hadn't thought to use such a wide range of social science methods at different times in response to differing needs? What if we hadn't learned to 'run with people's energies' and had instead rigidly stayed with 'Plan A'?

What were the primary conditions for the success of our project? From the above we might conclude they can be grouped into themes of participation: communities of inquiry with enough driving energy, enough understanding and skills regarding the wisdom of group inquiry processes over individual ones; respect (even love); an understanding of the operation of power relations (and empowering as well as disempowering relations) and enough freedom to construct a critical mass of empowering ones; the personal strengths and courage of participants; imagination; and action: over time; across space; persistence; iterative and emergent processes; and a strong and driving consumer perspective combined with a strongly humanist perspective and determination to act in concert with non consumers; and research: enough of a culture favouring non-positivist, constructivist, participative and non authoritarian or 'objectivist' inquiry methodology; record-keeping skills, and technical research and evaluation knowledge.

And the conditions for the future decrease of damaging experiences for those admitted to acute psychiatric hospital wards? Perhaps exactly the same. The jury is still out. What of the future

beyond this implementation and that by other services which has commenced following from our experiences and findings? The Staff-Consumer QA seminar still meets, and attendances go up and down. Some staff will no doubt continue to avoid consumers and their input - or accuse them of demoralising them; some consumers will go on wanting nothing more to do with the system; some staff, including managers—even the most committed—will go on habitually resorting to 'power-over' strategies (even when they do not need to); and some consumers will go on feeling hurt and discouraged; some staff, including managers will go on wanting to work with consumers despite the discomfort; and some consumers will go on wanting change and remaining hopeful despite the incessant knock backs. The managers may or may not cut the funding at the end of any next financial year. In the wider world, the Department will oscillate between criticising and supporting the services system, and the public will oscillate between criticising and supporting the services system too.

Maybe we are too close in time to the changes we have put in place to see their real effect. Certainly the 'coming out' and speaking for themselves of psychiatric service-users, particularly high-profile, well-known and often tertiary-educated service-users, is appearing to have as profound an impact as the comparable 'coming out' of people with intellectual disabilities, gay people, Aboriginal people and other suppressed voices has had. Whether it shifts the deep underlying fears of people-whose-minds-are-different-or-tortured remains to be seen, just as we perhaps do not yet know whether other deep historically-enduring forms of fear and reactive thought and action are shifting to give way to wider forms of, and processes, for understanding and respect.

COMMENTS:

Most of these benchmarks speak to the role of the "leader" in the story and the theory note. The leader is akin to the "midwife" described in Chapter 4. Thus, while all partners participate in accomplishing these benchmarks, it becomes the evaluable responsibility of the leader/midwife to ensure that they are achieved.

Theory Notes from Story:

In exploring a problem/issue and seeking to address it, we might form partnerships with other groups and organisations which share an interest in the problem/issue, and a common vision for action. Some salient features of forming partnerships include:

- bringing those affected by the problem/issue into the process in order to promote the relevance of any activities;
- having a facilitator who is acceptable to all original partners;
- appreciating the life cycle of partnerships—from initiation, through development and motivation.

Partners will bring expectations to the partnership. These are important and need to be named. As partners develop their working relationship, they may experience flux in (a weakening or strengthening of) their relationships. Changes among partners takes time, persistence and even luck. Persistence is needed to overcome differences and contradictions between partners. Changes valued by partners can be assisted or hindered by (unexpected) developments elsewhere in the system. Some surveillance by partners is therefore valuable to identify opportunities and threats to their partnership work in the wider environment.

As the partnerships mature, a deepening of understanding of each other's position, views and 'undiscussables' are likely to develop. Communication between partners can foster achievement of mature relationships, and needs to be multiple, open and enable all people's stories to be told and heard.

The initial conditions which may indicate that a partnership could be formed include:

- organisations and players who have same core objectives
- a group of people who can speak for themselves and are strongly committed to achieving change
- a person or organisation who is trusted sufficiently to take a facilitator role
- a recognition by several, if not all of the players, that changes are necessary in the way things are presently done
- the domain is not totally dominated by some powerful players, even if they are committed to change; there must be some willingness to negotiate power amongst the different partners

During a partnership it can be expected that:

- each party will continue to clarify their objectives
- there will be a growth in the extent of agreement about issues between the parties
- the parties will acknowledge that there are needs and issues specific to the parties which may conflict with needs and issues of others
- the partnership activity will wax and wane according to circumstances such as external threats and opportunities, leadership, and the trust between the parties
- there will be increasing recognition that some progress can be made acting together which cannot be achieved acting separately

The mature partnership will be characterised by:

- willingness to put certain objectives on hold or modify them in recognition of the value of the partnership
- an understanding among the parties that injuring other parties is not in their own best interests
- some respect and understanding for the feelings, views and positions of the parties for one another

The motivation for establishing a partnership is based on a recognition that no individual group can achieve the goal/objective without entering into a partnership. A catalyst is required to identify the need. The catalyst (midwife) can be helped by bringing together a critical reference group, possibly a large group within which there may be particular members with special skills and/or influence. This group would select a facilitator, who would work toward ensuring the partners maintain a 'working' relationship. This relationship will be not purely a consultation process but one of active partner participation, and the venting of opinions and feelings.

Finally, the difficulty of partnering (and achieving change) is in direct proportion to the level of paradox and contradictions and inequalities of power between the partners.

Benchmarks:

A facilitator acceptable to all potential partners is found.

A reference group for the facilitator of representative partners is established.

All persons or groups significantly affected by the problem/issue are involved in the partnership.

All partners can speak for themselves (express their autonomy) and are committed to changing how things are currently done.

No partners have so much power that they can unilateraly dominate; all partners agree to power-sharing.

STORY NO. 3: GATHERING PACE (PERSONAL ASSESSMENT AND CRISIS EVALUATION): A NOVEL PARTNERSHIP BETWEEN ADOLESCENT CLINICAL SERVICES

Story-teller: Associate Professor Pat McGorry
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The Early Psychosis Prevention and Intervention Centre.
Funded by VicHealth using the tobacco levy.

This story focuses on a novel partnership developed between my service, EPPIC, the Centre for Adolescent Health (CAH), and the Older Adolescent Service (OAS). The origins of the partnership lay in the development of the EPPIC program, which was planned during 1991 and began operations in 1992, and the potential links between this venture and the Centre for Adolescent Health, a health promotion oriented service for young people based at the Royal Children's Hospital.

During 1991, while I and my colleagues were planning the EPPIC program we submitted a research program grant to the Victorian Health Promotion Foundation (VHPF) which included a research focus on pre-psychotic high risk young people. The grant generally aimed to develop preventive interventions in psychotic disorders and one exciting possibility was the detection of young people in the prodromal phase of illness prior to the onset of psychosis. I believed, as with EPPIC, it would be vital to establish a clinical service to get to understand the special features and needs of the population and subsequently to carry out research which would enhance our capacity to predict more accurately who would become psychotic and to intervene to prevent that outcome.

The opportunities for partnership here were encouraging through the recent establishment of the Centre for Adolescent Health (CAH) on the one hand, and the Older Adolescent Service on the other. The key personal relationships here were important too. Prof. Glen Bowes as Director of CAH was a forward looking prevention-oriented clinician who had acted in a flexible and optimistic environment at CAH and was open to partnership. He wished to establish a mental health focus within the CAH and had involved Dr. George Patton, whose research interests were clinical and epidemiological, and whose clinical role was at that time team leader of the Older Adolescent Service. I invited Glen to become a founding patron of the nascent EPPIC service and discussed with George the possibility of establishing a clinic at CAH, a non-stigmatising location, for "prodromal" psychosis. I had by that stage obtained research funding support to develop the project further and had recruited a research assistant whose honours psychology thesis was in the area of psychosis-proneness in adolescence. I did not yet have a clear idea of who would clinically staff the clinic, though I did approach a senior registrar within EPPIC, who had expressed interest. She however carried out an EPPIC-based project on the subject of prodromal psychosis during 1993, and the clinic did not take firm shape at that stage. Dr. Patton also recruited a B.Med.Sci. student to join the nascent team, and also enabled us to piggy-back on the CAH's general school survey to examine the frequency of prodromal symptoms in a general population of adolescents.

As the clinic took shape, we named it the rather nondescript "PACE" clinic, or "Personal Assessment and Crisis Evaluation" clinic. This was to avoid alarming the young people about the level of risk for psychosis which was at that stage not known for the sample. The clinic was held one afternoon per week at CAH and was staffed clinically from EPPIC but with some input from one OAS staff member. Problems arose from a lack of clarity about roles of clinicians, lack of clarity regarding the clinical and research leadership, and a lack of administrative support and medical record procedures. Nevertheless, there was substantial goodwill and a commitment to an exciting area of work that all participants felt was "cutting edge". The project also gave tangible shape to the key symbolic linkage between EPPIC and the CAH. This was important in the formation of a blended service, the Centre for Young People's Mental Health (CYPMH), which was formed in 1996 from the EPPIC and OAS services, and which was intended to be a sister or complementary service of the CAH. While a number of tensions have arisen internally at times and more recently have been generated externally around this merger, much of this has been due to large scale changes in the structure and funding of health services in Victoria and in our health region. The venture overall has been successful to date. Apart from being a building block in the formation of CYPMH, PACE has established itself as a viable clinic and research structure with three published papers describing its work to date. A number of clinical/research writers in Europe and North America are seeking to replicate it as a model, and the data collected so far are extremely important and interesting. Substantial additional research funding has been attracted for the venture. The original partnership has remained intact and has strengthened.

Theory Note from Story:

Clarity of vision supported by common goals and objectives maintains momentum. There must be mutual respect of all partners' perspective. Vision needs to be translated into structural process and agreements.

The health promoter must recognise and respect the role the key partners play. Structures would reflect partners' current roles. These roles, however, likely will change as a project develops and there needs to be an opportunity to renegotiate the partnership.

It is important that there is initially a lack of formal structure to facilitate creation of a common vision. However, as a partnership develops and grows in its recognition by others, its importance and credibility can be inhibited by a lack of formal structure. In particular, new partnerships often develop over time; without a formal structure, and there will be unclear delineation of new partners' roles. Lack of a formal structure can also slow down decision making, leading to an imbalance of ownership and causing uncertainties in where to look for future development.

Benchmarks:

All partners vote on common goals and objectives, and results are minuted.

Goals and objectives are revisited at key benchmark points throughout the program.

A committee of management is established with all partners equally represented.

The roles and responsibility of key partners should be recognised and clearly delineated, with a formal written understanding between partners and a ratification of these understandings by institutions and other team members.

A management plan and structure should be put in place, including an evaluation process.

The roles of partners should be reviewed regularly with a view to need for change, including an annual review meeting of project progress and tasks involving all partners.

Meetings should review the completion of or difficulties in completing tasks, and examine problems in partners carrying out their implementation roles.
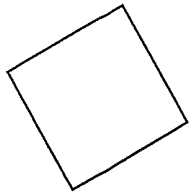
CHAPTER 7:

A Meta-Synthesis of Creating Partnerships and
A Reflection on the Process

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INTRODUCTION

Previous Chapters reviewed theories and stories about experiences of power, participation and partnerships, all of which were put into a context by Elizabeth Reid's opening comments (Chapter One) and Ronald Labonte's socioenvironmental models of disease and health (Chapter Two). This Chapter concludes by providing a meta-synthesis of all of the theory notes by Ronald Labonte, and closing remarks by Elizabeth Reid.

CREATING PARTNERSHIPS

On the one hand, it is unsurprising that the theory notes convey similar statements about the process of creating effective partnerships, and that these statements resemble those taken from the literature and summarised in Chapter Four. After all, these theory notes are written at a fairly abstract or general level and many of them raise as many questions as they answer. On the other hand, the degree of consistency among them is surprising, since they were generated by stories that involved differing partnerships in differing contexts with differing themes or content. But that is the very purpose of the story/dialogue method: To create generalisable practice knowledge that applies in different contexts, with different program or project content.

What, then, are the generalisable stories of creating effective, health-promoting partnerships? Readers may induce their own "meta-synthesis" of the previous Chapter; what follows is one interpretation only. One criteria for validity in the constructivist paradigm, on which the story/dialogue method is based, however, is that its findings are useful to and usable by others. To the extent that the meta-synthesis that follows meets these demands, the story/dialogue method will have fulfilled its goals.

Where Partnerships Begin

Partnerships begin when an organisation or group begins tackling a problem or issue for which it alone lacks the knowledge, resources or power to resolve. This "lead" organisation seeks out groups and organisations (potential partners) which share an interest in the problem or issue. Partners can self-select or be specifically chosen (sought out) by the initiating organisation. Potential partners should have a sufficiently thick overlap in core individual organisational objectives that a superordinate (common) goal can be defined. They also should have their own leaders and members capable of "speaking their voice." Partnerships where funding coerces membership are unlikely to be sustainable in the long-term, and may have difficulty reaching agreements over shared and divergent agendas.

Potential partners should be brought into a process with one another as early into activity planning as possible. This avoids too much of a power imbalance between them and the initiating organisation. It also ensures that the activities undertaken by the partnership are relevant to the constituents (members, clients, communities) of the different organisational partners.

A fundamental prerequisite to creating a partnership is the willingness of all potential partners to compromise somewhat on their individual agendas. This creates a relationship where confidence and trust can be established. But before entering into any partnership, the long term consequences of making compromises to an organisation's core values must be considered. Sometimes it is very easy to be seduced by a more powerful and/or alluring partner and for that reason it's important to stand back and identify the risks and opportunities that the relationship may hold. It is probably helpful for an organisation to have clear guidelines and criteria for assessing sponsorship/partnership offers/proposals.

Finally, forging successful partnerships depends on a thorough analysis of the current social, economical and political climate. The aims of the partnership should be congruent with, or at least acceptable by, a sufficient number of key stakeholders and/or community members.

Facilitating Partnership Development: The Midwife's Role

"Know thy partner!" Partners will bring different expectations to the partnership. These are important and need to be named. A midwife is required to identify these differing expectations and needs, and to "broker" the partnership. This midwife (variously called a "leader," "facilitator" or "catalyst" in the theory notes) must be neutral, both politically and organisationally. He or she may be employed by the initiating organisation, but at a minimum must be acceptable to all potential partners and be seen to be working for the partnership, and not any one group within it.

The midwife works initially to develop mutual respect for the differing perspectives and agendas of the potential partners. For respect and trust to develop, each potential partner must be clear and honest about their expectations of the partnership. Differences in expectations need to be raised and discussed. To accomplish this, the midwife needs to be able to unpack the agendas of different partners (which are often hidden) and to understand fully their individual motivations, interests, goals and values.

As the different partners negotiate their work, control of the negotiations and the partnership change process itself must be maintained by the member groups, and not by the midwife. This is a challenging facilitation task, which can be helped by bringing together a critical reference group to support the midwife. This reference group could be comprised of a number of members from different partner organisations with special skills and/or influence.

These broader skills are helpful in ensuring that the full range of potential partners are supported in their participation, and that the midwife does not overstep the bounds of his or her own skills.

All change agents in the partnership process, and especially midwives, need to be open and prepared to learn from others, and to welcome challenges to their own ideologies, principles and actions. This takes courage and a readiness to take risks. Ethical and moral behaviour needs to underpin all phases of partnership development. Personal commitment and confidence are essential attributes.

Creating a Partnership Vision

Effective partnerships require the establishment of a clear vision which speaks to the ethical and moral underpinnings of the work of member organisations, and to which individual participants can make personal commitments. The vision should define the role of the partnership members in acting towards its (the vision's) accomplishment, both as these organisations function in the present and how they should function in the future. (Visions are always future-oriented.) The vision should allow member groups to define what the partnership will achieve in both the short term and the long term, and allow for development of strategies that will take the partnership there. It is easier to develop a vision if all of the member groups have a clear understanding of their own, and other groups', values and principles.

Defining a Superordinate Goal

Creating a partnership vision cannot be separated from defining a superordinate goal (often referred to in theory notes as a common, shared or mutual goal). Effective midwifing in the early stages of a partnership is essentially a search for this goal; it is not, and should not be, an attempt to "please all the partners," since that will bog the partnership down in endless process and power struggles.

When such a goal, and the roles of different partners in accomplishing it, are not clarified and negotiated to the satisfaction of all partners, unequal power relationships develop, frustrations and anger accumulate, egos are damaged or defended and the project (shared partnership activities) is negatively affected.

The superordinate goal and partnership roles should be established both at the inception of the project, and reinforced at regular reviews during the life of the partnership. Such ongoing monitoring ensures that divergent agendas can be acknowledged, accommodated and managed, especially as new partners join and old partners leave.

Identifying Partners

It is essential to identify key partners to ensure any long-term sustainability for the partnership. Key partners may be those who have certain forms of "power-over" in relation to the issue, often through their control over funding relationships. The legitimacy that comes from the participation of a major "player" in the area of the problem or issue can also help to motivate the participation of other potential partners.